LESLIE LOBEL CONSULTING, LLC

Intake and History

PATIENT INFORMATION

LAST NAME	FIRST NAME	BIRTHDATE (MO/DAY/YEAR)	
HOME PHONE	GENDER ❑ MALE ❑ FEMALE	AGE	SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP CODE
CURRENT SCHOOL	CITY	GRADE LEVEL	

PARENT/GUARDIAN INFORMATION

LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT	
HOME PHONE	WORK PHONE	CELL PHONE	
ADDRESS	CITY	STATE	ZIP CODE

REFERRAL SOURCE

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MEDICAL HISTORY/DIAGNOSIS

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CURRENT MEDICAL PROVIDERS/INTERVENTION SERVICES

Please state any prior treatments or therapy the patient has received on the lines provided.

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MAJOR AREAS OF CONCERN

Please state reason for pursuing consulting services.

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